Analysis of American Recovery and Reinvestment Act
Date: February 13, 2009

HEALTH AND HUMAN SERVICES

Enhanced Federal Medical Assistance Percentage (FMAP) (Title V, Sec 5001)
Hold harmless. The state's FMAP for federal FYs 2009, 2010 and the first federal fiscal quarter of 2011 (through December 31, 2010) would be no lower than the state's FMAP for FY 2008.

Across-the-board increase. All states would be eligible for a 6.2 percentage point FMAP increase beginning October 1, 2008 through December 31, 2010, after application of the hold harmless provision.

High unemployment states. States with significant changes in unemployment would be eligible for an additional FMAP increase determined through a formula as described below.

States would be evaluated on a quarterly basis. The reduction in the state share would be based on the state's unemployment rate in the most recent three-month period for which data are available compared to its lowest unemployment rate in any three-month period beginning on or after January 1, 2006. The unemployment adjustment tiers are:

- 5.5%: unemployment increase of at least 1.5 but less than 2.5 percentage points
- 8.5%: unemployment increase of at least 2.5 but less than 3.5 percentage points
- 11.5%: unemployment increase of 3.5 percentage points or more

The state's percentage reduction could increase over time as its unemployment rate increases, but if unemployment decreased, the state share would not decrease until the fourth quarter of federal FY2010, which begins July 1, 2010, unless the state otherwise did not meet certain requirements as described below. The state would receive 60 days notice if its share of Medicaid costs were scheduled to increase after this time.

Calculation: If the state qualifies under one of these unemployment tiers, the state would still receive the 6.2 percentage point increase, however, it is easier to think of this as two separate increases of 3.1 percentage points (see Examples A and B below). There are three basic steps for the calculation of the unemployment adjustment:

- Step 1: An increase of 3.1 ***percentage points (half of 6.2)*** in the state's FMAP
- Step 2: A decrease in the state match by the ***percent*** corresponding to the applicable unemployment adjustment tier
- Step 3: Increase the FMAP by an additional 3.1 ***percentage points (the remaining half of 6.2)***

EXAMPLE A: The state FMAP is 50 percent and there was a change in unemployment rate for the quarter of 1.2 percentage points.

- *Step 1: Increase FMAP by 3.1 percentage points:*

FMAP = 50+3.1= 53.1. State share is now 46.9

- *Step 2: Determine unemployment factor, which because the unemployment rate was below 1.5, is zero.*
- *Step 3: Increase FMAP by an additional 3.1 percentage points: FMAP = 53.1+3.1= 56.2*
- *RESULT: state share is 43.8, federal share is 56.2*

EXAMPLE B: The state FMAP is 50 percent and there was a change in unemployment rate for the quarter of 2.0 percentage points.

- *Step 1: Increase FMAP by 3.1 percentage points: FMAP = 50+3.1=53.1. State share is now 46.9*
- *Step 2: Determine unemployment factor: 2.0 percentage point increase qualifies state for 5.5% reduction. Multiply your state share by this percent: 46.9*.055=2.58. Therefore reduce the state share by 2.58 percentage points: 46.9-2.58= 44.32. Result: state share 44.32, federal share 55.68*
- *Step 3: Increase FMAP by 3.1 percentage points: 55.68+3.1= 58.78*
- *RESULT: state share is 41.22, federal share is 58.78*

Commonwealths and Territories. They may choose the 6.2 percentage point increase plus a 15 percent increase in the capped amount or a 30 percent increase in the capped amount.

Application of FMAP to other programs/services. FMAP increases do not apply to payments for Title IV Parts A (Temporary Assistance for Needy Families, TANF), B (Child and Family Services), and D (Child Support and Establishment of Paternity), the State Children's Health Insurance Program (SCHIP), disproportionate share hospitals (DSH), and other enhanced payments based on FMAP.

Title IV-E: The hold harmless and 6.2 across-the-board percentage point increases in FMAP do apply to Title IV-E payments (Foster Care and Adoption Assistance). However, reductions in the state share due to the unemployment-related increase do not apply.

***Requirements and Restrictions*.** ARRA includes several requirements/ and restrictions and prohibits the HHS Secretary from waiving these. These include:

- States may not have eligibility standards, methodologies, or procedures in place in the Medicaid state plan or a Sec. 1115 waiver program that are more restrictive than those in effect as of July 1, 2008.
  - Any state that implemented more restrictive policies since July 1, 2008, has until July 1, 2009 to restore such policies. The state would then be fully eligible for the enhanced match, retroactive to October 1, 2008.
  - Any state that implements more restrictive policies as of July 1, 2008 and restores such policies after July 1, 2009 will be eligible for the enhanced FMAP beginning with the first calendar quarter that it restored the eligibility policies.

- Certain exceptions apply for delay in approval of a plan or waiver.

- The FMAP increases do not apply to payments for individuals enrolled in Medicaid as a result of an expansion in the state income eligibility policies implemented on or after July 1, 2008. States would still receive their regular FMAP for such individuals.
- The state must report on compliance with provider prompt payment requirements beginning with the date of enactment of the ARRA. Extends prompt pay requirements to nursing facilities and hospitals beginning June 1, 2009. Allows the Secretary to waive this requirement in certain situations.
- The state may not increase the percentage of the non-federal share it requires from local governments, above that in place as of September 30, 2008. This requirement is not applicable for the hold harmless.
- Prohibits states from depositing funding from the increased FMAP rate into any state reserve or rainy day fund. This does not apply to increases due to the hold harmless.
- Increases may not result in the state FMAP being greater than 100 percent.
- State must submit report on its use of the additional federal funds from the enhanced FMAP By September 30, 2011.

Federal Oversight of Medicaid Funds

The Act appropriates an additional $31.25 million for the HHS Office of Inspector General (OIG) for October 1, 2008 through September 30, 2011. These funds are intended to be used to ensure the proper expenditure of federal Medicaid funds. In addition there is $5 million in FY2009 to the Centers for Medicare and Medicaid Services (CMS) for implementation and oversight of the state fiscal relief provisions relating to Medicaid.

Temporary Increase for Disproportionate Share Hospitals Payments (DSH) (Title V, Sec 5002)

Temporary 2.5% increase in the state Medicaid DSH allotment for FYs 2009 and 2010. For FY 2010, the increase is based on the adjusted FY 2009 level.

Medicaid Regulations (Title V, Sec 5003)

Delays or addresses several Medicaid regulations, including:

- Extends the current moratoria (P.L. 110-252), on three Medicaid regulations through June 30, 2009: optional targeted case management services (TCM), school administration and transportation services, and provider taxes.
- Applies a new moratorium through June 30, 2009 to the final regulation regarding Medicaid outpatient hospital facility services (73 Federal Register 66817).
- Includes a "Sense of Congress" that the HHS Secretary should not issue final regulations for pending rules on: cost limits on public providers, graduate medical education (GME) payments and rehabilitative services.

Transitional Medical Assistance Extension and Reporting Requirement (Title V, Sec 5004)

Extends the Medicaid Transitional Medical Assistance (TMA) option for 18 months, through December 31, 2010. It gives states the option to extend the initial period of

eligibility for TMA to 12 rather than the current six months and to waive certain enrollment requirements, beginning July 1, 2009.

Beginning July 1, 2009, states would be required to report monthly enrollment and participation rates for adult and child enrollees and the number of these who become eligible under another Medicaid category or for SCHIP.

Qualifying Individual Program Extension (Title V, Sec 5005)
Extends through December 31, 2010 the Qualifying Individual (QI) program.

- $412.5 million is allocated from January 1, 2010, through September 30, 2010.
- $150 million is allocated from October 1, 2010, through December 31, 2010.

State Option for Family Planning Services. No provision.

Medicaid Provisions Impacting American Indians (Title V, Sec. 5006)
The Act includes provisions impacting health care for American Indians, including:

- Prohibits state Medicaid programs from imposing cost-sharing requirements on Medicaid-eligible American Indians when the beneficiary is receiving services from an Indian health care provider or from a Contract Health Services (CHS) provider.
- Exempts certain tribal, religious, spiritual, or cultural property from being considered an asset of an individual Indian for purposes of determining Medicaid and SCHIP eligibility or estate recovery.
- Requires states consult on an ongoing basis with Indian Health Programs and Urban Indian Organizations.
- Applies Medicaid and SCHIP managed care rules to Indian health care providers.

COBRA Healthcare for the Unemployed (Title III, Sec. 3001)
Under current law, individuals losing employment may be eligible to continue their employer-based health care coverage under a program known as COBRA. This entitles the individual to continued access to the same health plan they were receiving, but the individual is generally responsible for 102% of the total cost of the monthly premium.

***COBRA continuation subsidy*.** The COBRA continuation subsidy is available to individuals involuntary separated from their employer on or after September 1, 2008 and before January 1, 2010. The federal subsidy is 65% of the monthly COBRA premium for the individual – and their spouse and dependents – for a period of nine months. The Act places an income threshold on eligibility for the subsidy of $145,000 for individuals and $290,000 for couples. The subsidy is phased-out for individuals with income between $125,000 and $145,000 and couples with income between $250,000 and $290,000.

The subsidy is payable directly to the health plan or other eligible entity as an offset in payroll taxes. It does not count toward the individual's gross income with respect to taxation or eligibility for other government programs. Individuals are no longer eligible for the subsidy once they are eligible for another group health plan.

Eligible COBRA plans. COBRA continuation coverage is that required to be offered by the employer or under a state program that provides continuation coverage comparable to that the individual received from their former employer ("mini-COBRAs"). It also includes continuation coverage requirements that apply to health plans maintained by the federal government or a state government.

The individual may chose a COBRA continuation plan that is *different* than the one he/she was enrolled in at the time of separation as long as the plan is:

- Approved by the employer;
- Available to active employees of the employer;
- The premium for the different coverage is not higher; and
- The different coverage is not: service specific, for example dental or vision only coverage, a flexible spending arrangement, and on-site medical care coverage only.

State Medicaid option for the unemployed. No provision.

Health Information Technology (HIT) (Title XIII)

In brief, ARRA lays the foundation to adopt national HIT standards, provide incentives for adoption and use of HIT, and addresses privacy and security issues. The proposal includes approximately $2 billion to invest in health information technology infrastructure and $17 billion in incentives for Medicare and Medicaid providers.

Office of the National Coordinator for Health Information Technology (ONC). The ARRA codifies the ONC for Health Information Technology within the Department of Health and Human Services and defines the duties of the National Coordinator, which would include developing standards, coordinating HIT policy across policies and programs within HHS and across other executive branch agencies, and updating specific aspects of the Federal HIT Strategic Plan (developed as of June 3, 2008). The bill requires that this plan address utilization of electronic health records by 2014. It also would create HIT Policy and Standards committees, though state representation is not specifically required.

National standards. By December 30, 2010, it requires the Secretary to adopt an initial set of standards, implementation specifications, and certification criteria. It makes adoption of certain standards and certifications by private entities voluntary.

State grants to promote HIT (Title XIII, Sec. 13301). The proposal would establish a program whereby states or a state-designated entity could receive grants for planning or implementation to assist with and expand adoption of HIT. For grants awarded prior to FY 2011, the Secretary may determine if a state match is appropriate. Beginning in fiscal year 2011, there is a state match requirement that is equal to or greater than a defined percent of the federal contribution for grants awarded in FY 2011 as follows:

- FY 2011, not less than $1 for every $10 of federal grant funding;
- FY 2012, not less than $1 for every $7 of federal grant funding; and
- FY 2013 and thereafter, not less than $1 for each $3 of federal grant funding.

The proposal directs assistance for implementation of health information technology, with the goal that funding could be used for the following

- HIT architecture that will support the nationwide electronic exchange;
- Integration of HIT into training of health professionals and others in the healthcare industry;
- Training on and dissemination of information on best practices to integrate HIT into a provider's delivery of care. Such efforts must be coordinated between HHS and state agencies administering Medicaid and the State Children's Health Insurance Program (SCHIP);
- Regional or sub-national efforts towards health information exchange;
- Infrastructure and tools to promote telemedicine; and
- Promotion of the interoperability of clinical data repositories or registries.

Grants to states to create loan programs. The proposal would create a competitive grant program to allow eligible states or Indian tribes to establish a certified electronic health record (EHR) technology loan fund.

Grants to states/tribes could be awarded no earlier than January 1, 2010. States would be required to match federal contributions of at least $1 for every $5 in federal grant funding. Public funds and private sector contributions are permissible sources for the non-federal match.

The loan fund would allow states/tribes to distribute a loan to a provider or other eligible entity if the provider/entity agrees to certain requirements, for example providers must agree to report on quality measures. Private sector contributions to the loan fund are permissible. Loan funds could only be used for specified EHR-related technology purposes.

Medicaid HIT-related funding* (*Title IV, Sec. 4201). States may reimburse eligible Medicaid providers for the cost of qualified electronic health record (EHR) purchases, implementation and certain operation costs. The federal financial participation (FFP) rate for such payments is:

- 100 percent for Medicaid providers' purchase of certified EHR, including training and maintenance.
- 90 percent for certain administrative expenses.

The reimbursement payment for non-hospital based Medicaid providers with 30 percent Medicaid caseload is:

- 85 percent of the net allowable costs incurred for the purchase, implementation, and use of certified EHR technology.
- A separate reimbursement is applied for children's and acute care hospitals.
- Other hospitals are to be reimbursed according to the Medicare incentive policy.

The higher FFP is contingent upon states meeting several requirements, including:

- Determine providers are demonstrating "meaningful use" of the EHR technology, as determined by the state and HHS Secretary;
- Reimburse providers directly, without a deduction or rebate; and
- Track the use of EHRs, conduct oversight, encourage adoption of certified EHRs and exchange of health care information.

Limits are placed on provider "incentive" payments – which may be more appropriately characterized as a reimbursement payment, including:

- $25,000: maximum net allowable costs for purchase and initial implementation.
- $10,000: maximum net allowable costs for subsequent year EHR related expenses.
- $63,750: aggregate maximum net allowable costs.
- Reimbursement is limited to five years and cannot be provided after 2021.
- Providers would be responsible for any technology related expense not referenced.

The Act seeks to minimize duplication and harmonize requirements for providers participating in both Medicaid and Medicare.

Privacy provisions (Title XIII, Sec. 13400). The proposal includes provisions to strengthen privacy and security laws impacting identifiable health information. It does not appear to preempt state law. Provisions address breach notifications processes. It does not include a private right of action. It would provide some enforcement authority on behalf of individuals to states' Attorneys General and would establish a method to distribute civil monetary penalty or monetary settlements collected.

Prevention and Wellness Fund

$1 billion is designated for the Department of Health and Human Services to administer a "Prevention and Wellness Fund." HHS must provide Congress with operating plans prior to obligating any monies from the Fund in fiscal years 2009 and 2010. These funds are to be distributed according to the public health priorities of the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention (CDC). Specific funding allocations include:

- $300 million for the CDC 317 immunization program;
- $650 million for evidence-based clinical and community-based prevention and wellness strategies, authorized under the Public Health Services Act and determined by the Secretary, that deliver measurable health outcomes that address chronic disease rates; and
- $50 million to states to implement healthcare-associated infection prevention strategies.

Healthcare Effectiveness Research

$1.1 billion is provided to speed development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies. The bill establishes the Federal Coordinating Council for Comparative Effectiveness Research which is tasked with coordinating comparative effectiveness and related health services research

conducted or supported by federal departments and agencies in order to reduce duplication and leverage resources.

Community Health Centers (CHCs)
$1.5 billion is directed to federally qualify health centers (FQHCs) for construction, modernization, health information technology improvements. An additional $500 million is appropriated for FQHC grant funding for services and operations.

Training Primary Care Providers
The ARRA makes additional investments in health care workforce development programs, including:

- $300 million for the Nation Health Service Corps recruitment and field activities.
- $200 million for primary care medicine, dentistry, public health and preventive medicine program, scholarship and loan repayment programs under PHSA Titles VII and VIII, and cross-state licensing for health specialists.

Aging Services Programs
An additional $100 million is provided for certain "Aging Services Programs" included in the Older Americans Act.

Indian Health Service Facilities
Approximately $727 million is to modernize hospitals and health clinics and make healthcare technology upgrades in underserved rural areas.